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A HEALTHY FUTURE FOR ALL

A CLOSER LOOK AT BARRIERS TO HEALTH

A healthy future for all

A closer look at barriers to health

Guidance paper

Norwegian Red Cross and IFRC

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The International Federation of Red Cross and Red Crescent Societies (IFRC) is the world's largest volunteer-based humanitarian network. We act before, during and after disasters and health emergencies to meet the needs and improve the lives of vulnerable people. We do so with impartiality as to nationality, race, gender, religious beliefs, class and political opinions.

Our strength lies in our volunteer network, our community-based expertise and our independence and neutrality. We work to improve humanitarian standards, as partners in development, and in response to disasters. We persuade decision-makers to act at all times in the interests of vulnerable people. The result: we enable healthy and safe communities, reduce vulnerabilities, strengthen resilience and foster a culture of peace around the world.

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The reviewing committee consists of Dr. Jenny Reid, Dr. Claudia Vivas Torrealba, Morten Tønnessen-Krokan, Kathrine Holden and Frederic Francois Siem (The Norwegian Red Cross), Dr. Lasha Goguadze (IFRC). Johanne Sundby, professor global health, University of Oslo read and commented on draft paper.

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Cover photo: Colombian Red Cross provides health care and protection of health care workers and facilities in Valle del Cauca, Colombia. The use of the emblem provides protection for Red Cross volunteers and staffs during missions.
Photographer: Morten Tønnessen-Krokan/Norwegian Red Cross

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Executive summary

The world is experiencing record levels of humanitarian needs.[1] The recent and concurrent triad of conflict, climate change and the COVID-19 pandemic has exacerbated humanitarian needs around the world. These drivers have significant impacts on health.

Populations living in fragile, conflict-affected and vulnerable settings[a] face barriers to accessing health, which increases health inequities and hinder progress towards achieving universal health coverage. Barriers to health can be economic, political, epidemiological and socio-cultural.[2] Many barriers have been made worse by the impacts of conflict, climate change and the COVID-19 pandemic.

The International Red Cross and Red Crescent (RCRC) Movement is making an important contribution to building resilient and equitable health systems, including preparing for current challenges and future threats to public health security. This includes work at the national level by RCRC National Societies, in close cooperation with public health authorities.

Efforts focus on leaving no one behind and identifying and responding to barriers to health that are faced, in particular, by populations living in conflict-affected and vulnerable settings. In these contexts, the RCRC Movement remains heavily engaged in work to support communities overcome barriers and anticipate, prevent, mitigate, respond to and recover from rising disasters, health crises, risks and vulnerabilities.

Primary health care is and should be regarded as the cornerstone of universal health coverage. Strengthening health systems and improving access to quality, integrated primary health care for people living in the most vulnerable settings is critical. Furthermore, **people should be able to access necessary, lifesaving and urgent care, regardless of financial ability.** We must leverage the experience of the pandemic and strengthen global public health. Ultimately, we must build better, more resilient health systems, including to counteract the impacts of climate change.

a According to WHO, the term 'fragile, conflict-affected and vulnerable' describes situations of crisis induced by humanitarian crises, protracted emergencies or armed conflict. Given the dynamic nature of fragility, conflict and vulnerability, settings are juxtaposed across a spectrum of stability, depending on different contextual factors. At one end lie the clear-cut fragile, conflict-affected and vulnerable settings that experience severe, complex and often protracted crises. On the other end are settings in long-term states of stability and prosperity. *Retrieved from:* WHO (2020) Quality of care in fragile, conflict-affected and vulnerable settings: taking action. In: https://www.who.int/publications/i/item/9789240015203

1. Introduction

Health inequities continue to hinder progress towards achieving the Sustainable Development Goals, particularly Goal 3: 'Ensure healthy lives and promote well-being for all at all ages'.[3] Health inequities not only persist but have been exacerbated in recent years by the impacts of national, regional and international conflicts, the impacts of climate change and the indirect impacts of the pandemic.

In addition, 'low-income countries face multiple economic challenges—including rapid inflation, food insecurity, costly borrowing, and mounting debt'.[4] This has severe impacts on out-of-pocket health spending.

This situation translates into real barriers to health care as reported in this paper by Red Cross and Red Crescent staff and volunteers in Afghanistan, Burkina Faso, Honduras, Somalia and Yemen. Since a lack of reliable data, specifically for the most hard-to-reach populations, further increases the invisibility of these impacts,[5] **the stories of the staff and volunteers** may provide valuable insight into why and how people are being cut off from health services.

This paper points out some of the barriers to health care, such as attacks on health care; unaffordable health services where people face high out-of-pocket costs; transportation to health facilities; disrupted health systems in conflict-affected settings and overwhelmed services.

In fragile, conflict-affected and vulnerable settings (hereafter referred to as humanitarian crisis settings), the population groups frequently affected by health problems and facing barriers to health services are women; children under the age of 5; individuals displaced from their place of origin and survivors of sexual and gender-based violence (SGBV).

'Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.'[6]

The information presented in the report was compiled from 26 interviews with RCRC personnel, including 6 in-depth interviews, and this was complemented with information from different authoritative sources—data sets, official publications, studies and field reports.


Jeep

As the number of confirmed cases of COVID-19 increases in Burkina Faso (2021), volunteers from Burkinabe Red Cross are carrying out series of sensitization and mitigation activities against COVID-19 in internally displaced persons' camps in Kaya. A spread of the virus among IDPs could be devastating.

Photographer: Burkinabe Red Cross Society

2. Context

In a 2020 study, RCRC Movement partners highlighted how the confluence of crises, weak health systems, humanitarian response challenges and social determinants keep people from accessing health care.[7] Since then, armed conflicts have intensified health needs, the effects of climate change are more apparent, and COVID-19 has had massive consequences for health systems.

There are more than 100 armed conflicts in the world today.[8] The UN estimates that a quarter of the world's population is now living in settings affected by conflict, natural disasters and displacement.[9] In these contexts, healthcare systems are disrupted, and populations have reduced access to essential healthcare services. Climate change is the single biggest health threat facing humanity and health professionals worldwide are already responding to the health harms caused by it.[10]

The compounding impacts of environmental degradation, climate change and armed conflict have far-reaching implications for human security. They can limit access to the resources needed for people's survival, hinder the capacity of health systems, disrupt livelihoods and reduce adaptive capacity at the individual and community levels.[11]

Globally, climatic shocks are increasing in frequency and severity.[12] Climate change has increased the frequency of heatwaves, storms and floods, as well as disrupted food systems and increased water- and vector-borne diseases.[13] Around the world, these phenomena have had a disproportionate impact on vulnerable, isolated and marginalised populations, and may cause population disruption and migration.[14]

Between 2030 and 2050, climate change is expected to cause approximately 250 000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress alone.[15] Forty per cent of the countries experiencing a food crisis in 2017 faced the double burden of climatic shocks and conflict.[16] In addition to affecting the health of the population, climate change interferes with the functioning of health systems.

Electricity and water supplies may also be disrupted in relation to conflict or climatic shocks.[17] This can pose challenges for healthcare service delivery and medication storage, particularly medications that require a cold chain. Disruption or destruction to water supplies can affect the water, sanitation and hygiene in a healthcare service.

COVID-19 has had an impact on the health of the population worldwide, but incidence, hospitalisation and mortality rates have been grossly unequal between population groups.[18] Populations living in humanitarian crisis settings faced challenges such as higher rates of chronic disease; greater exposure to infectious agents; lower capacity to adhere to public health and social measures; and reduced access to health services for treatment and vaccination.[19] During the height of the COVID-19 pandemic, there were disproportionate disruptions to essential health services in already weak health systems. After the first year of the pandemic, 94% of countries and territories reported some kind of disruption to healthcare services.[20]

These disruptions encompassed primary health care and rehabilitative, palliative and long-term healthcare services. In addition to the disruption in service coverage, financial protection was

Kabul, Indira Gandhi Hospital. A 3-year-old boy suffering from malnutrition receives treatment at the hospital. He and his mother drove urgently from Baghlan Province to Kabul three weeks before.

Photographer : Glinski, Stefanie / ICRC

particularly poor in low- and middle-income countries and lower-income households.[21]

Although, on average, disruptions were reported in almost half of services worldwide (45%), significant variations were observed between regions and income groups.[22] Beyond disrupting routine healthcare service provision, COVID-19 led to a global re-deployment of resources away from certain areas (e.g., specific disease campaigns, sexual and reproductive health) and aggravated existing barriers to health care, particularly for those living in vulnerable settings.[23]


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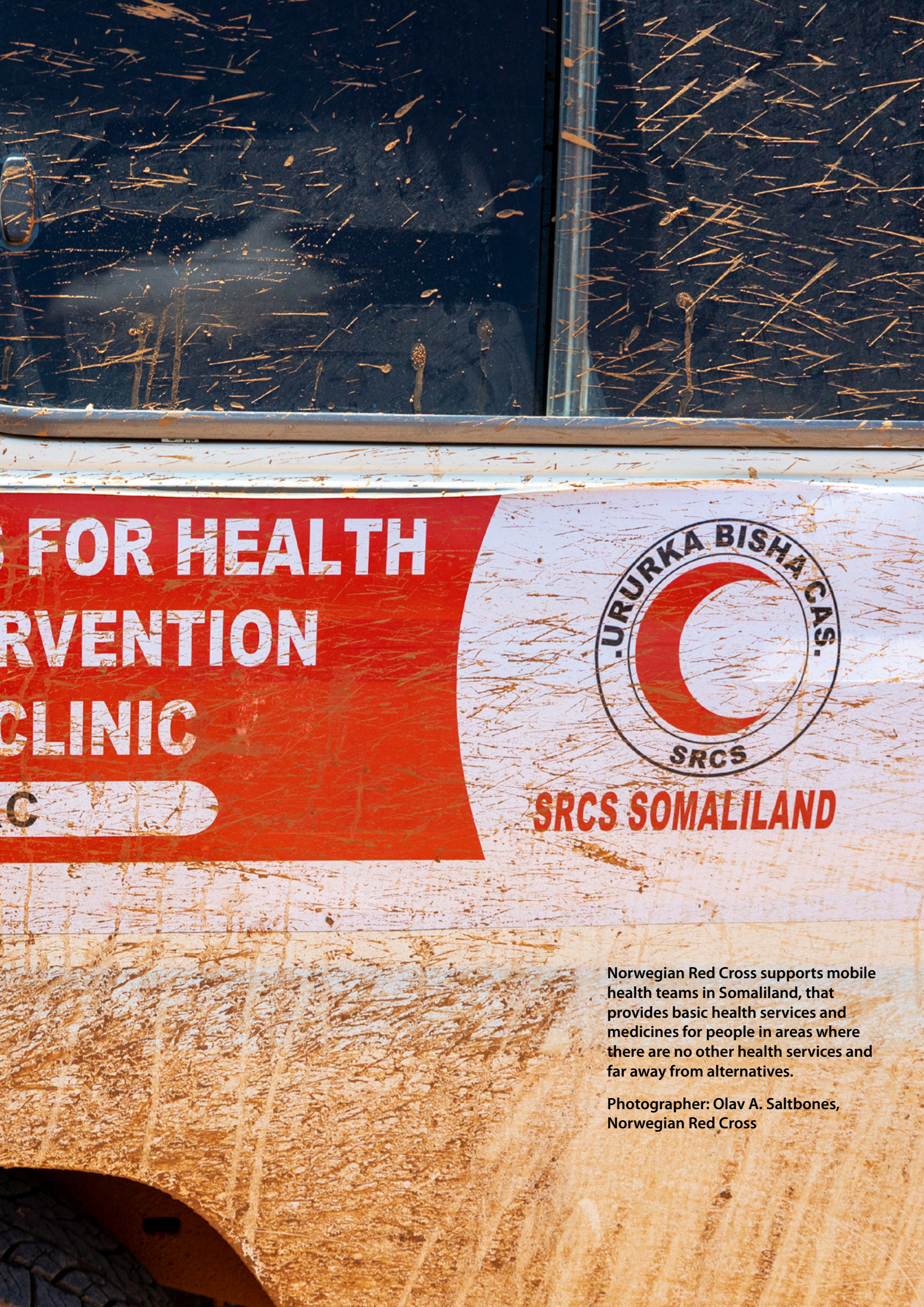


Norwegian Red Cross supports mobile health teams in Somaliland, that provides basic health services and medicines for people in areas where there are no other health services and far away from alternatives.

Photographer: Olav A. Saltbones, Norwegian Red Cross

3. Barriers to health

There are multiple barriers to health, and these vary from country to country and sub-nationally. Barriers to health can be economic, political, epidemiological and socio-cultural.[24] **It is important to break down these barriers to help understand how to improve access to comprehensive services.**[b25] In this report, we have chosen to focus on the following specific barriers, identified by RCRC personnel working in contexts facing a humanitarian crisis, including Burkina Faso, Somalia, Afghanistan, Honduras and Yemen.

Attacks on health care

'Violence on health care is a persistent feature that continues to characterize conflicts and other emergencies today. Health-care personnel, patients, facilities, and vehicles are frequently attacked during armed conflict despite being protected under international humanitarian law.'[26]

The ongoing armed conflict between Russia and Ukraine illustrates this point. So far, the conflict has resulted in more than 1 150 reported attacks affecting the healthcare system, adding to the immense pressure on the Ukraine's healthcare system.[27] However, attacks on health care globally are significantly underreported.[28]

'The Ukrainian Red Cross with support from the RCRC Movement provides basic medicines and medical equipment to health facilities across Ukraine, including 93 mobile medical units, providing vital medical care to people living in hard-to-reach areas throughout the country.'[29]

In conflict-affected contexts, patients already grapple with restricted mobility from curfews, road closures and other obstructions. Deteriorated road conditions lengthen travel times and heighten exposure to violence. For healthcare workers, the risks are amplified. Identified as care providers, they become potential targets, not only at medical facilities but also during commutes. Insecurity threatens health providers and restricts the mobility of the teams that implement outreach activities in hard-to-reach areas. Their security is vital; without it, the continuity of healthcare services is at stake.[30]

Gayéri is a district in Burkina Faso that is predominantly controlled by armed groups. The territory is currently under blockade, isolated, with radical restrictions on entry and exit. There, the operation of the health system has been strongly impacted by conflict since there have been direct attacks on health facilities. According to the Ministry of Health (2022), in the regions most affected by insecurity, 37% of health facilities are closed or partially operational.[31] In Gayéri, the medical centre and the district hospital are completely closed. Only the Primary Health Care Centre is in operation. This is run by volunteers who attend the maternity unit, the dispensary and the nutritional recovery and education centres.[32]

b A 2022 study based on an electronic search of all studies that identified the challenges of worldwide universal health coverage only found 26 out of 2500 articles.

> *In Gayéri district, the healthcare infrastructure does not comply with standards. Armed groups have destroyed electricity and drinking water facilities; there is no electricity and water distribution is interrupted. Therefore, infection prevention cannot be done properly.*
>
> - Red Cross team, Burkina Faso (Interview 24/07/23)

'The collapse of the health system [in Gayéri] has a serious impact on health promotion and disease prevention. There has been a decline in vaccination coverage and routine epidemiological surveillance which has led to the re-emergence of diseases that have been under control for years, such as febrile jaundice and acute flaccid paralysis.'[c]

Understanding and fostering trust within diverse cultural, religious and traditional contexts is pivotal for the acceptance of healthcare services. Factors such as a breakdown in primary care can erode trust in the health system. It is essential that our healthcare approach is not only efficient but also resonates with the unique needs and perspectives of the communities we serve. Elevating health literacy is key, and will ensure that communities are well-equipped to make informed health decisions.

Health services are unaffordable

Today, about 2 billion people are facing catastrophic or impoverishing health spending. In 2017, this figure was between 1.4 and 1.9 billion.[33], [34] Inadequate financial protection mechanisms in health lead to financial hardship due to out-of-pocket health spending and financial barriers to access health care.[35]

Context specific circumstances can weaken public health systems. In settings facing conflict or a protracted crisis there is often chronic underfunding and underinvestment, resulting in a further weakened health system. In situations where a health system is weak or overwhelmed, people often face higher out-of-pocket spending, including having to seek expensive alternatives such as private services.

> *'In the Kaya district [in Burkina Faso], services are free for pregnant women and children under 5 years old. The rest of the population has to pay for health services but cannot afford them. People turn to the humanitarian sector or use traditional medicine. Traditional medicine is the priority for them.'*
>
> - Red Cross team, Burkina Faso (Interview 24/07/23)

c Norwegian Red Cross internal report (2023)

Ukrainian Red Cross operates mobile health units across Ukraine to support people affected by the international armed conflict between Russia and Ukraine.

Photographer: Camilla Gilje Thommessen/Norwegian Red Cross.

Power and water supplies are disrupted

According to WHO, water, sanitation and hygiene (WASH) services in healthcare facilities, across all regions, fall short of international and national standards.[36] Gaps in access to WASH services in countries facing prolonged disruption to critical public services or governance are also reflected in shortages of safe drinking water and safely managed sanitation facilities in healthcare centres. This hinders the role of health facilities in reducing diseases and can instead contribute to more infections, prolonged hospital stays and preventable deaths.[37]

Violence and power outages in protracted conflict settings mean that most health facilities operate on restricted hours. They must also operate solely in the daytime when there are fewer risks to the safety of users and health teams. This means that when emergencies occur at night, people must go directly to the hospital. The same thing happens in many settings where there is a lack of access to the basic level of health care. Ultimately, this congests specialised health services, interferes with referral systems, impacts health promotion and disease prevention activities, and contributes to the collapse of the health system.

As a result of climate-related extreme weather events, countries worldwide are struggling with electricity supply.[38] In settings where there are poor earthing systems, power outages are not only an impediment to the operation of medical equipment, but they also put the lives of staff and patients at risk. One of the most serious consequences is that the intermittency of the electricity supply poses difficulties for the storage of essential medicines that require refrigeration, such as vaccines.

> *'In the Sool region [in Somalia], the health facilities would not work 24 hours a day. They work only from morning to afternoon because it is risky for people and for the health workers to stay in the facility when there's no lights at night. This means nobody can receive service at night.'*
>
> - Red Crescent team. Somalia. Interview (19/07/23).

Health facilities are understaffed

WHO recognises that in humanitarian crisis settings securing an adequate workforce—in terms of numbers and necessary skills—is a common challenge.[39]

The reasons for the insufficient availability of specialised health staff vary from context to context. However, in most humanitarian crisis settings, this is related to significant financial and resourcing constraints, weaknesses in the educational system, and the preference of the workforce to work in the urban capitals where they have better working conditions and are less exposed to violence. This leads to an inadequate workforce, in terms of numbers and skills.[40]

> *'Right after the change of government, international supporters cut off their funding to Afghanistan. Due to limited funding and budgetary issues, partners are not in a position to provide training to their staff. So, staffing as well as having trained personnel, are key gaps in the Afghan health system.'*
>
> - Red Crescent team. Afghanistan. Interview (13/07/23).

Across the country, Somali Red Crescent Society (SRCS) teams run static and mobile health clinics that serve rural and remote communities in hard-to-reach areas. These clinics provide basic health care and routine immunizations, as well as screening for malnutrition and providing nutritional support. The staff refer severe cases of malnutrition to larger medical centres and hospitals. More than 300,000 people received healthcare from 13 clinics in Somaliland and Puntland in 2022.

Mobile health clinic in Higlo. Luul Hashi Biihi (30) has six children and has brought her son Saki Said Aden (4) to this clinic.

Photographer: Camilla Gilje Thommessen / Norwegian Red Cross

‘In Afghanistan, despite the political turmoil, the Afghan Red Crescent continued to be one of the key main health care providers for the population. In 2022, the Norwegian Red Cross-supported medical teams delivered 1.6 million health consultations while over 171,000 pregnant women were vaccinated and over 181,000 children were immunised.’

The insufficient supply of health providers, mainly specialists, coupled with insufficient opportunities for training limits the capacity and speed of medical care. This scenario also minimises the use of advanced medical equipment for diagnostic and treatment purposes, and it restricts certain populations’ access to health. Finally, it contributes to the fact that complementary services are expensive and are concentrated in urban areas and in the private sector.

Transportation options are scarce

In conflict-affected settings, the actors involved in the conflict often impose curfews and road closures, and even enforce invisible barriers to restrict mobility. Moreover, the roads deteriorate as a result of the armed confrontation and the lack of investment in infrastructure.[41] Adding to that, the severity of storms and floods have made the state of the road network in some settings worse. These hinder the operation of transportation and the circulation of ambulances and, with it, the transportation of people to health facilities. Furthermore, in conflict-affected settings, disrupted travel times to health facilities due to damaged roads increase people’s exposure to violence.

Chamelecón is one of the most dangerous neighbourhoods in San Pedro Sula, Honduras. It has alarming unemployment rates, massive displacement, and escalating rates of violence due to the presence of gangs. Informal boundaries imposed within a gang-controlled area mean that people must go to the health facility in their sector, despite the one on the other side being closer in many cases. In Chamelecón there are two Public Primary Health Care units, the Manuel Trochez Health Care Unit and the San Antonio Health Care Unit. Depending on their location north or south of the border they offer services to the colonies in their sector.[42]

> *In Chamelecón (Honduras), the invisible borders produced by the rivalry between the gangs, restricts the implementation of extramural activities and the provision of mental health services, pap smears, family planning, and educational workshops.’*
>
> - Red Cross team, Honduras. Interview (20/07/23).

Trauma, rehabilitation services and protection systems are weak

In humanitarian crisis settings there are often poor health protection services within public health systems, especially to support survivors of SGBV.[43] Furthermore, despite its relevance in conflict-affected contexts, the availability of services for mental health is often low.[44] Depression and anxiety affect one in five people

in emergency and conflict situations.[45] Many settings already affected by armed conflict also have weak trauma, rehabilitation and protection systems.[46]

> *'Physical rehabilitation services are often limited in the country [Somalia]. There are a maximum of 3 or 4 physical rehabilitation centres throughout the country, all of them located in urban settings. Therefore, people who live in rural areas really cannot access or need to travel a long way just to reach those centres.'*
>
> - Red Crescent team. Somalia. Interview (19/07/23).

Insufficiency and low quality of medicines and medical equipment

Health facilities often do not have the consistent and reliable stock of medicines, equipment and supplies that is needed to deliver quality care. This has to do with inefficient procurement and supply chain systems and with the lack of relevance of care standards developed for non-crisis settings. This situation is also associated with the fact that, in contexts that face protracted governance disruptions, processes to ensure the quality and proper storage of essential medicines and medical supplies may be eroded.

> *'The availability and quality of medicines is a problem in Yemen. In Lahj Governorate, the storage of medicines cannot always be trusted, as some essential medicines must have a certain temperature and there are frequent power outages. Also, importing medicines is not that easy; it may take months to complete the import.'*
>
> - Red Crescent team. Yemen. Interview (21/07/23.)

The shortage of medicines prevents patients from following and completing the treatments they require; it weakens the population's trust in health services; and it discourages attendance at medical services, since diagnoses alone do not solve patients' health needs.

> *'In Honduras, the shortage of medicines for special programmes such as tuberculosis or diabetes has undermined the confidence of users in the public health system and altered their health-seeking behaviour. This shortage of medicines is related to issues throughout the supply chain in the prioritization, acquisition, distribution, and storage stages.'*[47]
>
> -La Asociación para una Sociedad más Justa (2022) Estado de país salud: Honduras.

Afghan Red Crescent Society's Parwan branch mobile health team. A midwife is checking the health of the villagers. Location: Bagram, Parwan Province, Northwestern Afghanistan

Photographer: Meer Abdullah / Afghan Red Crescent Society

4. Population groups facing disproportionate barriers to health

Within humanitarian crisis settings, there are populations that face disproportionate barriers to accessing health services. The specific population groups vary according to the setting and socio-cultural context, but include women, children under five; displaced individuals, and survivors of SGBV.

Women and girls

In fragile settings, girls are disproportionately exposed to practices that might include **unwanted pregnancies and lack of family planning options.** These practices have significant consequences on health (e.g., greater exposure to sexually transmitted diseases; infections; and psychological trauma) and educational outcomes.[48]

Economic crises, natural disasters, pandemics and conflicts in vulnerable settings exacerbate the health risks women and girls face. For example, mortality is three times higher among women of reproductive age living near high-intensity conflicts than women in peaceful settings.[49] This may be a consequence of greater exposure to SGBV.[50] Conflict also leads to increases in malnutrition, physical injuries, infectious diseases and the deterioration of mental health and sexual and reproductive health.[51]

Overall, fertility rates, especially adolescent fertility rates, are higher in fragile contexts compared to other settings. This is partly due to less awareness of and access to family planning and cultural practices, such as early marriage. High fertility rates in vulnerable contexts are coupled with much higher maternal risks, including eclampsia, systemic infections and complications during childbirth, to the point that in 2019, 75% of all maternal deaths globally occurred in fragile settings.[52]

In Afghanistan and Somalia women face barriers to health care and health problems that go beyond those orchestrated by conflict and climate change

In Afghanistan, women must attend health facilities in the company of a mahram.[d] In Somalia, they require approval from male relatives to consent to procedures at hospitals. These issues delay critical and life-saving interventions. Furthermore, the lack of availability and willingness of relatives to accompany them and the costs of reaching a health facility—which are doubled with a companion—limit women's access to health services.

Moreover, in Afghanistan, women can only receive health services from female health workers. This represents a great barrier considering the low availability of women doctors, nurses and midwives. In September 2021, the government banned women from taking a high school or university education, and from employment in non-governmental organisations. The latter has had dire consequences on women's access to health care. Two-thirds of 151 national and international organisations had stopped more than 70% of their activities by the end of 2022,[53] while the drop in the number of female health workers reporting to work means that female patients are hesitant to seek care.[54] Ultimately, the ban on education will affect the future availability of female health providers

d In Afghanistan, a 'mahram' is 'a husband, father or brother, who acts as a travel companion as the Taliban have ruled that women cannot travel by themselves'.

and, with it, the access of women and children to primary health care and complementary services due to a lack of specialists. Banning women from education has implications for their health and that of their family. Their lack of awareness about the consequences of poor sanitation and the importance of proper hygiene habits, as well as their limited knowledge of a good diet, affect the health of all household members.

Women also face challenges in meeting their sexual and reproductive health needs,[55] which is associated with the high rates of maternal mortality in both countries. In Afghanistan and Somalia, family planning remains a sensitive topic. Although around 63% of ever-married Somali women have heard of at least one method of contraception, only 7% are using any contraceptive method, and 1% are using modern methods.[56]

In addition, women in Somalia undergo harmful cultural practices that put their health at risk. Child marriage, and cultural norms associated with menstruation are harmful practices rooted in long-held beliefs. In relation to child marriage, 2% of 15-year-olds have started childbearing, which means that by the age of 19, almost 40% of women have had a baby or are pregnant.[57]

'In Somalia, in 2022, impressive maternal health wins stem from a number of factors: community health volunteers have actively reached out to pregnant women, obstetric services were provided in clinics, and several external partners of the Red Crescent helped train and upskill medical staff.'[58]

Children under five

Vulnerable settings have a particularly high burden of morbidity and mortality among children under the age of five.[59] UNICEF recognises that children living in conflict-affected areas often miss out on basic immunisation; almost half of unvaccinated and under-vaccinated children live in countries that are affected by conflict. Interruptions in routine vaccination are dangerous considering that children of that age are the most vulnerable to disease outbreaks such as measles and polio.[60]

Infant vaccine coverage has seen the largest recorded reduction in 30 years, and critical testing, treatment and prevention activities for infectious diseases and HIV have declined.[61]

The interruption of basic and essential services, secondary to conflict, climate change and the COVID-19 pandemic have particularly impacted children under five. Today, more than 30 million children in the 15 worst-affected countries suffer from wasting, and 8 million of these are severely wasted.[62] Likewise, there is proliferation of water-borne diseases, such as acute diarrhoea. Acute diarrhoea on its own, or as a concurrent disease with, for example, measles, typhoid fever or cholera, may result in child mortality.[63]

The disproportionate impact of food insecurity on the health of children under the age of five in Afghanistan

Food insecurity has disproportionately affected children in Afghanistan. According to UNICEF, in 2022, 1.1 million children under 5 years of age suffered from severe acute malnutrition and were at risk of death.[64] Kandahar is one of the two provinces in Afghanistan with the highest number of cases of severe acute malnutrition.[65] In addition, stunted children are more likely to contract diseases, less likely to get basic health care, and do not perform well in school.[66]

Adding to that, the recurring drought triggered a crisis of water scarcity, leading the population to significantly depend on groundwater to meet its water needs.[67] Contaminated water—by sewage and deadly pathogens—disproportionally affects and damages children's nutrition and health[68] due to the high prevalence of water-borne diseases such as diarrhoea.

In addition, amidst the complex emergency, children under the age of 5 face pressing health needs in terms of immunisation. Around 3.3 million children have gone unvaccinated against measles, polio, whooping cough, tetanus, diphtheria, pneumonia, meningitis and

tuberculosis since 2018.[69]

Displaced individuals

Conflict and the impacts of climate change can also lead to significant population displacement, within a country and also across borders. At the end of 2022, an estimated 108.4 million people in the world were displaced due to persecution, conflicts, violence and human rights violations.[70] Large population shifts can overwhelm or over-burden a health system. This can impact all aspects of the health system, including referral pathways and also public health preparedness and prevention. An already weak health system may not be able to cope with a sudden impact.

Displaced individuals often face specific challenges in accessing health care, such as geographical accessibility and mobility restrictions, lack of resources, language barriers, loss of medical records, health policies in the host country and stigma from providers and communities.[71] As a result of these barriers, the most pressing health needs of this population group can include untreated communicable diseases, poorly controlled chronic conditions, maternity care and mental health and specialist support.

Worldwide, the three main causes of morbidity amongst refugees and internally displaced persons (IDPs) are malaria, upper respiratory tract infections and lower respiratory tract infections.[72] Crowded living conditions, poor WASH services and limited access to health care are largely responsible for the prevalence of these infectious diseases and their severity among this population group.[73]

In addition to these health conditions, displacement can lead to food insecurity, including the disruption of infant and young child feeding and care practices and increased SGBV.[74]

IDPs in Yemen face additional barriers to health

Yemen has experienced large-scale internal displacement across the country since the conflict started in 2014. It is estimated that in 2022 there were over 4.5 million internally displaced persons, which is the second highest figure after Syria in the MENA region. Although conflict is the main cause of displacement, it has also been triggered by natural disasters. With over 171,000 movements, Yemen's figure represents 82% of flood displacements in the MENA region during the rainy season of 2022.[75]

Food insecurity, restricted access to WASH services, unmet housing needs, and additional barriers to employment expose IDPs to changes in their health and to additional barriers to overcoming these health conditions. About 26% of IDPs live in hosting sites where they are particularly exposed to unreliable service provision,[76] making them more vulnerable to disease outbreaks and exacerbating the risk of food insecurity and malnutrition. Additionally, in the places where they normally live, treatment for non-communicable chronic diseases and mental health issues is often unavailable.[77]

Neglect of mental health has disproportionate implications for the Muhamasheen, an ethnic group in the country who suffer from caste-based discrimination. This group is also more exposed to the spread of communicable diseases, and it faces difficulties in treating chronic diseases since most of them move to slums on the outskirts of cities.[78]

During the COVID-19 pandemic, IDPs in Yemen were more likely than the non-displaced to experience symptoms of the virus. Forty-five per cent of IDPs reported that someone in their household experienced COVID-19 symptoms, compared with 30% of non-displaced people.[79] IDPs were also less likely to receive treatment.[80]

Finally, internal displacement affects the operational capacity of health facilities. The lack of population estimates affects the operational capacity of primary health care units in terms of total healthcare services, target setting and resource allocation.

Survivors of sexual and gender-based violence (SGBV)

SGBV is widespread globally. Furthermore, evidence shows that SGBV increases in fragile conflict- and crisis-affected settings. In times of war and conflict, groups often use sexual violence—including rape, gang rape and forced witnessing of rape, forced or early marriage, forced pregnancy, and sexual torture—as a tactic of war to humiliate, dominate or disrupt social ties.[81] SGBV also increases during and after a natural disaster. Breakdowns in law and order and family structures increase women's vulnerability. However, SGBV in crisis situations also affects men, boys and gender minorities.[82]

In addition, as evidenced by COVID-19, threats to public health security can also cause a sharp increase in SGBV. For example, during the pandemic, there was an increase in SGBV. Considering this scenario—and that many cases go unreported—for every three months of confinement, an additional 15 million cases of SGBV were expected worldwide. This occurred because girls and women were confined to their homes with their perpetrator.[83]

Women and girls are disproportionally affected. Nevertheless, all survivors face the consequences of SGBV in contexts where there is a lack of

The Honduras Red Cross providing services to migrant people that cross through the southern border of the country, usually through Trojes or Las Manos.

Photographer: Honduran Red Cross Society

access to health services and poor educational and employment opportunities. The consequences of SGBV include injuries, unwanted pregnancy, fistula, STIs and psychosocial trauma. Furthermore, the effects are exacerbated for specific population groups such as refugees, people with disabilities and people belonging to ethnic minorities.[84]

Regardless of whether it is a setting affected by a conflict, a natural disaster or the outbreak of a pandemic (or all of these), survivors of SGBV face different barriers to meeting their health needs. Some of the most significant include the lack of commodities; lack of trusted and confidential spaces; poorly coordinated referral networks; lack of trained providers; stigma; and pressure to report the incident as a condition to access care.

Conflict and its implications for women's health in Honduras and Yemen

Honduras has been classified as one of the countries with the highest rates of violence in Central America. Gangs, better known as maras, are in a constant struggle for territory and resources in fragile environments where there are breakdowns in governance and where the institutional presence is very weak. Organised crime (mainly drug trafficking and extortion) and the recruitment of adolescents are key to the functioning of these groups. Evidence has shown that forced recruitment and perpetration of SGBV are closely linked.

Women face the consequences of urban violence first-hand, since SGBV has been used by the maras as a tactic of war. Beyond the repercussions that this causes in the physical and mental health of women of different ages, it is largely the cause of the high rates of teenage pregnancy.[85] SGBV—in the streets and at home— is coupled with generalised violence, the weaknesses of the health system in providing sexual and reproductive health services and psychological care, the impact of natural phenomena, and the feminisation of poverty. These factors have disproportionately affected women's well-being.

In Yemen, SGBV has intensified since the conflict began in 2014, especially in manifestations such as sexual harassment, early marriages and denial of inheritance. Additional types of violence that SGBV survivors experience include beating, cursing, shouting, mockery, verbal abuse, depriving girls of education, and restrictions on their movement. According to **United Nations Population Fund**, in the span of two years since the onset of the conflict in 2014, incidents of GBV increased by over 63%.[86] From the institutional side, there are weaknesses in mental health and psychosocial support management and referral.[87]

Nomadic communities

Nomadic communities—pastoralists, hunter-gatherer populations, sea nomads, and traders and craftworkers—are in constant movement. They generally travel through traditional routes, searching for resources and food. There is a lack of data and therefore no concrete estimates, but it is believed that in the 1990s there were approximately 30–40 million nomads.[88] Nowadays, forced resettlement, climate change, political unrest, armed conflict and assimilation into modern urban cities are threatening nomadic communities' lifestyle[89] and exacerbating the health barriers faced by these populations. Health barriers are complex and are driven by

internal and external factors ranging from their lifestyle, norms and practices to geographic isolation and political factors. The preference for traditional medicines, strong sociolinguistic barriers, and settlement in rural areas are some concrete barriers that result from the combination of these factors.[90]

Nomadic communities face significant health risks and poor health outcomes, including difficulties in maintaining adequate nutrition. They also experienced increased exposure to the transmission of diseases and conditions—such as chronic cough, asthma, bronchitis and arthritis—and less access to immunisation and other health services.[91]

The barriers to accessing medical care and the health needs of the nomadic population in Somalia

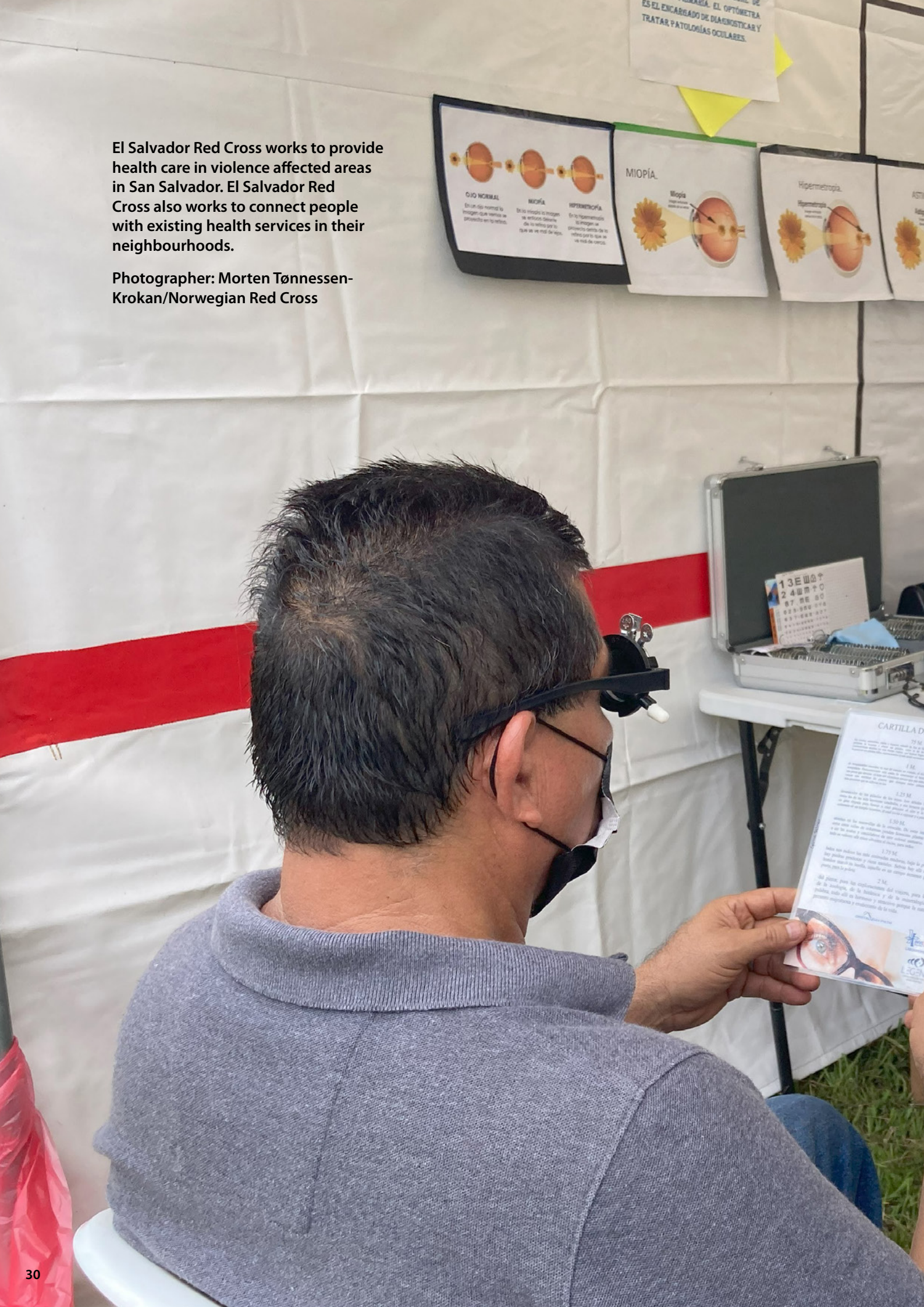
Somalia ranks as the second most vulnerable country to climate change in the world.[92] The increased frequency and severity of droughts, coupled with protracted conflict, have damaged Somalia's domestic food production. This has made the country dangerously dependent on high-priced imported grains, mainly from Ukraine and Russia.[93] Poor-to-failed harvests among farmers and declining livestock holdings among pastoralists have disrupted national food production, and therefore nutritional outcomes.[94] Spurred by declining incomes, nomadic households move—within and between regions, or even to neighbouring countries—and temporarily reside in settlements, where they can access pasture and water.[95]

As a result of disruptions in agriculture, it is estimated that in 2020 there were a total of 7.1 million people facing crisis-level food insecurity and 213,000 people at risk of catastrophic hunger and starvation in Somalia.[96] Due to insufficient donor funding to sustain humanitarian food assistance at the required levels, the nomadic population could reach crisis-level (IPC Phase 3) or emergency-level (IPC Phase 4) food insecurity by mid-2023.[97] In addition to food security, nomadic populations in Somalia face additional health conditions and barriers to health care.

Nomadic populations suffer the most from weakened government capacity to provide basic diagnostic services[98] and are highly reliant on external humanitarian assistance.[99] Even so, nomadic people with minority-clan affiliations are reported as the population group most affected by extortion and/or exclusion in aid delivery.[100]

Furthermore, only 1% of nomadic households have access to sanitation.[101] Overcrowded settlements with poor water and sanitation conditions increase the prevalence of measles and acute watery diarrhoea, among other diseases.[102] Similarly, children in nomadic households often miss out on routine vaccinations against childhood tuberculosis, polio, diphtheria, pertussis, tetanus, hepatitis B, Haemophilus influenza type B and measles.[103]

Finally, nomadic populations also suffer from medical conditions derived from the use of tobacco and chewing khat. Six per cent of members of Somali nomadic households chew or have chewed *khat* (stimulant) and/or smoke or use tobacco. This represents a higher percentage than for urban households. Tobacco use is a risk factor for medical conditions and contributes to poverty by diverting household spending.[104]



El Salvador Red Cross works to provide health care in violence affected areas in San Salvador. El Salvador Red Cross also works to connect people with existing health services in their neighbourhoods.

Photographer: Morten Tønnessen-Krokan/Norwegian Red Cross


Bello

5. Recommendations

1

Strengthen health systems and improve access to quality, integrated health services at the primary health care level for people living in the most vulnerable settings.

Primary health care is regarded as the cornerstone of universal health coverage and the most equitable, effective and efficient way to improve the health of populations.[105]

- **Identify barriers:** As part of primary health care, it is important to identify the different barriers to accessing health care that specific communities face, related to availability, accessibility, affordability and acceptability.

- **Expand coverage and improve quality of services:** Strengthen existing health systems and bring essential healthcare services closer to the population in the most vulnerable situations.

- **Harness inclusive community engagement** so that communities are empowered to participate in decision making, to strengthen accountability, to integrate community-based models of care and to promote health literacy.[106]

- **Ensure multi-sectional governance and leadership and strengthening global health coordination**. This includes strengthening stakeholder coordination between policymakers, civil society organisations, academia, media, the private sector, humanitarian agencies and development organisations.

- **Prioritise equity and ensuring protection, gender and inclusion** are part of integrated health approaches.

2

Build better, climate-resilient health systems focusing on primary health care as the foundation for universal health coverage

Climate change is the single biggest health threat that humanity faces. It has impacted the health of people in different ways, especially the health of those populations living in humanitarian crisis settings.[107]

- Mobilise a global commitment to health and climate and building climate-resilient health systems.

- Ensure a systematic and comprehensive approach to climate-resilient health systems that are able to anticipate, respond, cope, recover and adapt to the health risks caused by climate change.[108], [109]

3 Strengthen global public health security by leveraging the experience of COVID-19

Lessons from COVID-19 must be harnessed to strengthen global public health security. Universal health coverage and global health security[e] are two intertwined global goals.[110] COVID-19 demonstrated the need for resilient health systems, particularly during a global or national crisis.

- Ensure basic essential health care for all, with strengthened preparedness to prevent and respond to future health threats.
- Invest in a well-trained and competent health workforce to contribute to a resilient health system, able to prepare and respond to public health emergencies.
- Invest in resources and financing to build resilient health systems, able to respond to new and emerging health threats.

4 To achieve financial protection, health systems must 1) break down financial barriers to access services, and 2) ensure that out-of-pocket health spending is not a source of financial hardship for users.[111]

Financial protection: People should be able to access necessary, lifesaving and urgent care, regardless of financial ability. About 2 billion people are facing catastrophic or impoverishing health spending.[112]

- Promote increased public spending on health.
- Promote an increase in pooled health financing.
- Promote sustainable financing systems based on the country context.
- Align global health actors and development partners to support progress towards sustainable financing for health.[113]

As stated in the 2023 UHC progress report, 'a primary health care approach can improve health systems and accelerate progress toward UHC. Reaching the goal of UHC by 2030 requires targeted efforts building on strong data and evidence.'[114]

Breaking down barriers to health and working towards universal health coverage is a critical priority that requires multi-sectoral engagement and coordinated global and national commitment.

Different stakeholders, including the RCRC Movement, can contribute towards ensuring barriers to accessing health are understood and alleviated, particularly for the hardest to reach populations and populations living in fragile, conflict affected settings and those impacted by climate change.

e The World Health Organization defines global health security as the activities required—proactive and reactive—to minimise the danger and impact of acute public health events that endanger people's health.

WHO's 7 policy recommendations

WHO's 7 policy recommendations on building resilient health systems based on primary health care[115]

1. Leverage the current response to strengthen both pandemic preparedness and health systems
2. Invest in essential public health functions including those needed for all-hazards emergency risk management
3. Build a strong primary health care foundation
4. Invest in institutionalised mechanisms for whole-of-society engagement
5. Create and promote enabling environments for research, innovation and learning
6. Increase domestic and global investment in health system foundations and all-hazards emergency risk management
7. Address pre-existing inequities and the disproportionate impact of COVID-19 on marginalised and vulnerable populations

Afghan Red Crescent Society's Kapisa branch mobile health team doctor as he is doing checkup of the patients. Location: Kohband, Parwan Province, Northwestern Afghanistan.

Photographer: Meer Abdullah / Afghan Red Crescent Society

Across the country, Somali Red Crescent Society (SRCS) teams run static and mobile health clinics that serve rural and remote communities in hard-to-reach areas. These clinics provide basic health care and routine immunizations, as well as screening for malnutrition and providing nutritional support. The staff refer severe cases of malnutrition to larger medical centres and hospitals. The three rehabilitation centres delivered treatment (prosthetics and physiotherapy) to 8,000 people.

Photographer: Camilla Gilje Thommessen / Norwegian Red Cross

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